Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN7503	A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	05/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 831 SS=E	1200-8-6-.08 (1) Building Standards (1) A nursing home shall construct, arrange, and maintain the condition of the physical plant and the overall nursing home environment in such a manner that the safety and well-being of the residents are assured. This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the physical plant. The findings included: 1. Observation of the south nourishment room on 5/20/13 at 9:07 AM, revealed the sink leaking. 2. Observation of the staff break room on 5/20/13 at 9:19 AM, revealed the sink pulled from the wall. 3. Observation of the ceiling throughout the facility on 5/20/13, revealed water stains and damage to the ceiling. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 5/20/13.	N 831	1. Leaking sink in South nourishment room was repaired Sink in break room was secured to the wall. 2. A through audit was completed throughout the facility of all sinks for non-compliance. 3. Sinks operational status will be added to our weekday daily compliance rounds. These rounds are conducted by facility managers. Any non-compliance issues will be reported to the maintenance supervisor for correction. 4. The weekday outcomes will be included in the monthly Quality Assurance meeting . Any deficient practices and/or trends will be reported along with a plan of action to address these deficit practices. The Maintenance Supervisor will be responsible to remain in compliance with repairs as necessary. Annual survey resulted in citation for stained/damaged ceiling. The facilities plan of correction will include an inspection of the facility roof to determine the potential for deficit roof conditions contributable to the ceiling damage. Roofers conducted inspection.	5-20-13 5-27-2013 6-14-2013 6-14-13 6-17-13 6-12-13

Debbie Bowers
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 6/13/13

JUN 14 2013

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN7503	A. BUILDING: _____ B. WING _____	05/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
		N831	Do to the nature of the project; the facility has requested a 6 month extension of compliance on this roofing project. 6-13-13 Notification of completion will be submitted on a timely basis per our correspondence to Tennessee Department of Health. 6-13-13	

Division of Health Care Facilities

Debbie Bowers — TITLE: Administrator — (X6) DATE: 6/13/13

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM 6899 FB6B11

JUN 14 2013